

## Disease Detectives

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# Communicable Disease Control

## UPDATE

MECKLENBURG COUNTY HEALTH DEPARTMENT  
A Quarterly Publication

### We're #1!

We're **#1** and we don't want to be! In 2010, syphilis in Mecklenburg County is increasing at an alarming rate. In fact, Mecklenburg County could be facing its worst outbreak of syphilis in 10 or more years. In 2009, the early syphilis rate\* in Forsyth County increased from 13.4 %\* in 2008 to a record rate of 58.6 %\* pushing it past Wake and Mecklenburg counties. In 2009, Mecklenburg County showed an increase in early syphilis cases from 10.2%\* in 2008 (91 cases) to 19.5%\* (174 cases) reaching the highest level of early syphilis cases since 2006 with a rate of 21%\* (188 cases). From January through the end of May 2010, Mecklenburg reported approximately 90 early syphilis cases compared to 68 cases for the same time period in 2009. At this pace, Mecklenburg County will exceed the total number of early syphilis cases reported from last year's total of 174. If this trend continues, we will match or exceed the outbreak that occurred in 2006 (194 cases).

Private providers report 60-70% of early syphilis in the county. County and state Disease Intervention Specialists (DIS) in-

vestigate all reported cases. Their findings show that about 70% of the early cases are symptomatic. Males account for about 90% of the cases. About 45% of early cases are co-infected with HIV. About 75 - 80% of the cases denoted MSM (men who have sex with men) as a risk factor. In the last 10 years, there has been an age shift with a greater number of cases in the 20-29 age group instead of 30 - 39 years.

The Health Department has made syphilis a priority action item. In spite of recent budget cuts, additional staffing in our Outreach Program is planned due to successful grant activity. Plans are to increase awareness of the disease through education, increase testing efforts, peer counseling and a community Syphilis Elimination taskforce.

For more information, contact Jeffery Williams-Knight at 704.432.1506 or [Jeffery.Williams-Knight@MecklenburgCountyNC.gov](mailto:Jeffery.Williams-Knight@MecklenburgCountyNC.gov).

\*per 100,000 population

### Dear Private Medical Provider,

We are the DIS who investigate all cases of reported syphilis (and HIV) and their contacts and partners. Since you report the majority of syphilis cases in the county, we would like to present our "Wish List" for providers who see patients diagnosed with syphilis:

- Report the case as soon as possible to 704.432.1742. Internet and phone contacts are often lost just weeks after the person has tested reactive. Phones are disconnected or numbers

have changed. Many clients move several times in a month.

- Confirmatory testing is absolutely necessary. Without a confirmatory treponemal test, there is no actual case of syphilis and we cannot enforce control measures.
- A treponemal confirmatory test alone does not distinguish between active and past syphilis. A quantitative non-treponemal test helps you to compare past and present tests to determine infection.
- A skin rash is often the only symptom a patient reports. Dermatologists and

ED physicians, please consider syphilis in your diagnosis and test for it.

- If you test someone for HIV or any STD, test for syphilis.
- Proactively treat cases and/or partners and other high-risk individuals if symptoms of syphilis are present and don't wait for confirmatory testing.
- If you don't have bicillin in your practice, call us at 704.336.6438 and we will get some to you.
- Go to [MeckHealth.org](http://MeckHealth.org) for additional information.
- Thanks for all you do.

Sincerely,  
County & State DIS

## Immunization Requirements for Child Care

Every individual in North Carolina is required to be immunized by receiving the specified minimum dose of vaccine by the specified age according to the NC Immunization Schedule 10A NCAC 41A .0401. Alternative immunization schedules and non-religious personal belief exemptions are not recognized in N.C. The only immunization exemptions recognized in N.C. at this time are medical and religious. All children in N.C. are required to provide proof of current immunization status upon enrollment in a child care facility. A parent, guardian or responsible person must present a certificate of immunization on the child's first day of attendance to the child care facility. If a certificate of immunization is not presented on the first day, the child care operator must present a notice of deficiency to the parent, guardian or responsible person. The parent, guardian or responsible person has 30 calendar days from the first day

of attendance to obtain the required immunizations. Additional days, upon certification by a physician, may be allowed to obtain the required immunizations if the approved intervals require a period in excess of 30 calendar days. Upon termination of 30 calendar days or the extended period, the child care operator shall not permit the child to attend the child care facility unless the required immunization has been obtained. It has recently become popular among some parents to request an alternate vaccine schedule for their children. While alternate vaccine schedules are not acceptable in N.C., this type of request does offer the opportunity to educate parents on the facts of vaccination and the importance of the N.C. Immunization Schedule.

Vaccine-preventable diseases are still prevalent in the U.S., and in North Carolina. Multiple cases of

Hib, mumps, and especially high rates of pertussis are reported annually. Many of the people at risk for these diseases are those who have not been vaccinated or are under-vaccinated. During 2008, more measles cases were reported in the U.S. than in any other year since 1997. More than 90% of those infected had not been vaccinated, or their vaccination status was unknown. Although measles is uncommon in the United States, unvaccinated travelers visiting the United States can cause an outbreak among unvaccinated people and under-vaccinated communities. Although the risk is small this is a good example of how vaccine preventable diseases do still exist and can infect anyone that is not protected.

For more information, contact Beth Young at 704.336.5076 or [Elizabetb.Young@MecklenburgCountyNC.gov](mailto:Elizabetb.Young@MecklenburgCountyNC.gov).

## High Dose Influenza Vax for the Elderly



On December 23, 2009, the Food and Drug Administration (FDA) li-

censed an influenza vaccine that contains an increased amount of inactivated viral antigens. This vaccine is known as Fluzone High-Dose and it is manufactured by Sanofi-Pasteur. Fluzone High-Dose is licensed as a single dose for use among persons  $\geq 65$  years and should be available beginning fall 2010.

Prior to licensure, three studies of persons  $\geq 65$  years provided evidence that the Fluzone High-Dose vaccine resulted in higher titers against three influenza strains when compared to the standard dose Fluzone. It is unknown if Fluzone High-

Dose will result in less morbidity and mortality in the elderly. Compared to other age groups, the elderly respond to standard dose influenza vaccination with lower antibody titers. The Advisory Committee on Immunization Practices (ACIP) reviewed the data from the three studies on Fluzone High-Dose and expressed no preference for administering the new vaccine to the elderly. Fluzone High-Dose will contain the same recommended influenza strains as standard dose Fluzone.

All eleven brands of influenza vaccine this fall will contain A/California/7/2009 (H1N1)-like, A/Perth/16/2009/ (H3N2)-like, and B/Brisbane/60/2008-like.

For more information, contact Jane Hoffman at 704.336.5490 or [Jane.Hoffman@MecklenburgCountyNC.gov](mailto:Jane.Hoffman@MecklenburgCountyNC.gov).

This periodical is written and distributed quarterly by the Communicable Disease Control Program of the Mecklenburg County Health Department for the purpose of updating the medical community in the activities of Communicable Disease Control. Program members include: Health Director—E. Wynn Mabry, MD; Medical Director—Stephen R. Keener, MD; Deputy Health Director—Bobby Cobb; Director, CD Control—Carmel Clements; Sr. Health Manager—Wanda Locklear; CD Control nurses—Freda Grant, Jane Hoffman, Penny Moore, Elizabeth Quinn, Belinda Worsham; Childcare nurse—Elizabeth Young; TB Outreach nurse—Earlene Campbell-Wright (also Adult Day Health); Rabies/Zoonosis Control—Al Piercy; Sr. Health Manager STD/HIV — Lorraine Houser; Health Supervisor—Carlos McCoy; DIS—Mary Ann Curtis, John Little, Michael Rogers, Jose' Pena; Preparedness Coordinator—Bobby Kennedy; Preparedness Health Supervisor—Steve Newman; CRI Coordinator—Amy Williams; Regional Surveillance Team—Valerie Lott, Denise Wall, Vivian Brown; Office Assistants—Audrey Elrod, Natalie Jones

Lorraine Houser  
Carmel Clements  
Editors

## Typhoid Fever

Typhoid fever is a serious bacterial infection caused by the bacterium *Salmonella enterica* serotype Typhi. Typhoid fever remains common in the developing world where hand-washing is less frequent and water is contaminated with sewage. Worldwide, over 22 million persons each year are infected with 200,000 associated deaths. Approximately 400 cases occur each year in the United States. Symptoms of acute infection may include a prolonged fever, marked headache, weakness, abdominal pain, loss of appetite, and rose-colored skin rash. Complications include intestinal hemorrhage and/or perforation. Humans are the only reservoir. This disease is transmitted by ingestion of food or water contaminated with human feces or urine from infected persons.

North Carolina reported forty (40) cases of acute typhoid fever between 2003-2008. Eight (8) cases of acute typhoid fever between the ages of 5 and 30 years were reported in residents of Mecklenburg

County between 2005-2009. All eight reported travel outside the United States. Seven (7) reported travel to India. One (1) reported travel to Vietnam and Cambodia. None reported receiving typhoid vaccine within the two years prior to their travel. Five (5) were male and three (3) were female. None were employed as foodhandlers. Two (2) were siblings who traveled to India. As required by North Carolina law, all persons diagnosed with typhoid fever are required to submit stool samples until they have three consecutively negative stool cultures. No carriers were identified in Mecklenburg County residents during this five year period.

Two vaccines are available for persons traveling to endemic areas. The first vaccine is a single dose polysaccharide antigen vaccine approved for person's age 2 years and up. The second vaccine is a live, oral vaccine given in four doses approved for person's age 6 years and up. Unfortun-

nately, both vaccines are only 50-80% effective.

Using precautions with food and water while traveling in developing countries can prevent many illnesses including typhoid fever. The CDC recommends the following actions to avoid exposure to *Salmonella typhi* while traveling in developing countries: drink bottled *carbonated* water; avoid ice unless it is made from bottled or boiled water; eat foods that are thoroughly cooked and steaming hot; avoid raw fruits and vegetables unless you can peel them yourself; and avoid food and beverages from street vendors. Persons traveling to South Asia, East Asia, Southeast Asia, Africa, the Caribbean, Central America, and South America are at risk of infection. Travel recommendations can be obtained at the CDC web site (<http://www.cdc.gov/travel>).

For more information, contact Jane Hoffman at 704.336.5490 or [Jane.Hoffman@MecklenburgCountyNC.gov](mailto:Jane.Hoffman@MecklenburgCountyNC.gov).

## HPV Vaccines

The HPV vaccine is now available for males. Updated recommendations from the ACIP include:

- Quadrivalent HPV (types 6, 11, 16, and 18) vaccine (Gardasil®) may now be given to males aged 9- 26 years. Previously this vaccine was only recommended for females. Now both males and females can receive Gardasil®.
- Bivalent HPV (types 16 and 18) vaccine (Cervarix®) can only be given to females ages 9 thru 26 years.

Recommended dosage for the quadrivalent HPV and bivalent HPV

vaccine can be found in the [package inserts](#) listed on the FDA website. Both vaccines may be started beginning at age 9 through 26 years; quadrivalent and bivalent HPV vaccines are administered in a 3-dose schedule, with the second dose given one to two months after the first dose and the third dose six months after the first dose. HPV vaccines are not live vaccines and can be administered either simultaneously or at any time before or after an inactivated or live vaccine. Whenever possible, the same HPV vaccine product should be used for all doses in the series. Complete recommendations may be found at [www.cdc.gov](http://www.cdc.gov).

To be eligible for Gardasil® supplied by the North Carolina Immunization Program, females and males must be 9- 18 years and must meet the following eligibility criteria: Medicaid eligible, uninsured, Indian (American Indian or Alaskan native), or underinsured. For availability of State supplied Gardasil® vaccine for males, call Mecklenburg County Health Department at 704. 336.-6500 or 704. 353.1189.

For more information contact Freda Grant at 704.336.6436 or [Freda.Grant@MecklenburgCountyNC.gov](mailto:Freda.Grant@MecklenburgCountyNC.gov).

### Did you know...

...that on February 19, 2010, the FDA approved Novartis's license application for Meningococcal (Groups A, C, Y, and W-135) Oligosaccharide Diphtheria CRM197 Conjugate Vaccine? Trade named Menveo, the vaccine is indicated for active immunization to prevent invasive meningococcal disease caused by *Neisseria meningitidis* serogroups A, C, Y and W-135. It is approved for use in people ages 11 through 55 years. To date there are no ACIP recommendations or VFC resolution. Until those are in place the vaccine will not be available from the State but stay tuned for further information about this vaccine.

## Swim Season is Here

Although chlorine is an efficient way to kill most microorganisms found in recreational water, it is not immediately effective. Despite the use of chlorine in recreational water, many people have become sick with recreational water illnesses (RWIs), which are spread by swallowing, breathing in, or having contact with contaminated water from swimming pools, spas, lakes, rivers or oceans. The most commonly reported RWI is diarrhea. RWIs can be caused by microorganisms like *Cryptosporidium* (Crypto).

Crypto is one of the most common causes of RWIs in the United States and can cause prolonged diarrhea for 1-2 weeks. Parasites are carried in the intestines of cattle, pets and many other animals and are passed in their stools. Millions of Crypto parasites can be released in a bowel movement from an infected human or animal. Rain washes parasites into the rivers and lakes.

This parasite has a tough outer shell that allows it to survive for a prolonged time in the environment. Crypto is chlorine-resistant and can live for days in chlorine-treated water.

Persons infected with Crypto begin to show symptoms 2 - 10 days after exposure. Some people with Crypto do not get sick at all, but most have watery diarrhea and a low-grade fever. Other symptoms can include nausea, vomiting, headache and stomach cramps. The parasite will remain in the stool for several weeks. In a healthy person, the symptoms will last less than 15 days. Crypto may be more severe and last longer in young children, pregnant women, the elderly, and those with weakened immune systems.

The most common mode of transmission is swallowing contaminated water from recreational water such as pools, water parks, interactive fountains, hot tubs, lakes, rivers, springs,

ponds, streams and oceans. Other modes of transmission are eating raw or under cooked foods that have been contaminated with Crypto and hand to mouth after touching soil or objects contaminated with stool.

### Check the Water Quality

Check out whether bacterial levels in the water are monitored at your favorite beach and whether the beach is open for swimming by going to the EPA's website, [BEACON—Beach Advisory and Closing Online Notification](#). This information is available only for U.S. coastal/marine and Great Lakes beaches.

Inspection reports for Mecklenburg County pools can be found at the [Environmental Health website at MeckHealth.org](#).

For more information, contact Freda Grant at 704.336.6436 or [Freda.Grant@MecklenburgCountyNC.gov](mailto:Freda.Grant@MecklenburgCountyNC.gov).

## Dengue Infections

As summer approaches many relief organizations and churches will be leading volunteers and youth groups to Haiti to assist in the rebuilding efforts following the earthquake that struck outside Port-au-Prince, Haiti on January 12, 2010. Dengue is a mosquito borne infection endemic in Haiti and historically relief workers responding in previous disasters have reported high rates of infection. Therefore, the CDC Dengue Branch is advising physicians who evaluate travelers who return from Haiti with febrile illnesses, or a recent history of fever, should consult their local health department if dengue is suspected.

Symptoms of dengue include a high fever plus two of the following: headache, retro-orbital pain, joint pain, muscle or bone pain, rash, mild hemorrhagic manifestations such as nose or gum bleed, petechiae, or easy bruising, and leukopenia. The incubation period is usually one week but can be as long as 14 days.

Most cases can be treated with bed rest, acetaminophen, and oral fluids. A small number of patients develop dengue hemorrhagic fever (DHF), a much more serious infection. This form of the disease generally requires hospitalization.

Patients seen prior to travel to Haiti should receive instruction on the regular use of insect repellent. Since the *aedes aegypti*, one of the mosquitoes responsible for dengue transmission, is a "Day Biter", travelers should be cautioned to wear long sleeves and pants and use insect repellent on all exposed skin when outdoors or in an unscreened area either day or night.

Dengue is an emerging disease which has become a major global health concern over the past few decades. It is most prevalent in tropical and sub-tropical regions of the world, mostly in urban and semi-urban areas. In the U.S., locally acquired dengue has been reported

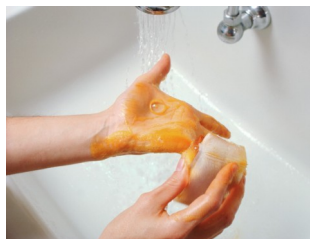
along the U.S.-Mexican border, Hawaii, and more recently, in Key West, Florida. Most travel related dengue cases are reported from travelers returning from the Caribbean, Central America, and South Central Asia.

N.C. has the species of mosquitoes which can be vectors of the infection. Should an infected traveler return to N.C. and be bitten by one of these mosquitoes, the mosquito could then become infected and spread the disease to other humans. Prevention is not only important for the traveler but to all who reside in areas, like N.C., where local mosquito populations could become infected by infected travelers. There have been 5 cases of Dengue reported in Mecklenburg County in the past 5 years.

For more information, contact Belinda Worsham at 704.336.5498 or [Belinda.Worsham@MecklenburgCountyNC.gov](mailto:Belinda.Worsham@MecklenburgCountyNC.gov).



## Postpartum Group A Strep



Group A streptococcus, or group A strep, is a bacterium commonly

found in the throat and on the skin. This bacterium can cause a range of infections, from relatively mild sore throats and skin infections to life-threatening invasive disease. Group A bacteria are spread by direct person-to-person contact and can usually be treated with antibiotics. There are two types of very serious group A strep infections, but the type most often seen in the postpartum patient is streptococcal toxic shock syndrome.

The sites of postpartum infection are varied, but endometritis is the most

common infection in the postpartum patient. Endometritis in the postpartum patient occurs at the placental site as a result of bacteria traveling up the genital tract from the vagina. The episiotomy wound or any lacerations of the vagina, vulva or cervix are sites of possible infection. Infections of other pelvic organs including the ovaries, peritoneum and the broad ligament, secondary to other infections may occur. Infections can spread from a sore throat or infected gums through the blood resulting in postpartum infections. Other sources of infection that are carried to the patient include doctors, nurses and other visitors. Infection can also spread from infected vaginal pads.

Postpartum patients are frequently discharged within a couple days following delivery. The short period of

observation time may not allow enough time to evaluate evidence of infection prior to discharge from the hospital. Signs and symptoms of postpartum infection include fever (>100), pain, vomiting, headache, loss of appetite and general malaise. To avoid the complication of Strep toxic shock syndrome in the postpartum patient, health care providers must provide meticulous wound care and must make the patient aware of the signs and symptoms.

Toxic shock syndrome, non-streptococcal and streptococcal, and Streptococcal infection, Group A, invasive disease are all reportable to the Health Department.

For more information, go to [www.CDC.gov](http://www.CDC.gov) or contact Penny Moore at 704.353.1270 or [Wilma.Moore@MecklenburgCountyNC.gov](mailto:Wilma.Moore@MecklenburgCountyNC.gov).

## FAQ

**Q.** What is ESBL-producing *E. coli*?

**A.** There are many strains of *E. coli* (*Escherichia coli*) that live in the intestinal tract of humans and other warm blooded animals. Most strains are harmless and aid in digestion. Extended-Spectrum Beta Lactamase *E. coli* (ESBL-producing *E. coli*) produce an enzyme which makes the organism resistant to several classes of antibiotics. ESBL-producing *E. coli* can cause a variety of illnesses including urinary tract and blood infections. The incidence is believed to be increasing globally. ESBL-producing *E. coli* infections are not reportable.

**Q.** What are the recommendations for vaccination of travelers to protect them from hepatitis A virus (HAV) infection?

**A.** The recommendations from the CDC state that (1) the hepatitis A vaccine is recommended for healthy susceptible persons ages 1-40 years who travel to or work in regions where hepatitis A is endemic and, (2) the hepatitis A vaccine should be given as soon as travel is considered, but it can be given any time prior to departure. For optimal protection, persons older than age 40 years, immunocompromised persons, and persons with diagnosed chronic liver disease or other chronic medical conditions, if departure will take place within two weeks, should also receive Immune Globulin (IG) simultaneously with the first dose of hepatitis A vaccine but at a different anatomic injection site. For travelers younger than age 1 year, IG alone is recommended because hepatitis A vaccine is not licensed for use in this age group. Hepatitis A is endemic in all regions except the United States,

Western Europe, New Zealand, Australia, Canada and Japan. Comprehensive travel recommendations can be found at [www.cdc.gov/travel](http://www.cdc.gov/travel).

**Q.** When is antimicrobial therapy used to treat MRSA (Methicillin-resistant *Staphylococcus aureus*) skin infections?

**A.** Incision and drainage is the primary therapy for purulent skin infections. Consider antimicrobial therapy if the patient has systemic symptoms, severe local symptoms, immunosuppression, or has not responded to incision and drainage. Options for empiric outpatient treatment are available at [www.cdc.gov/mrsa](http://www.cdc.gov/mrsa). MRSA is resistant to penicillins and cephalosporins. Fluoroquinolones and macrolides are not optimal for treatment of MRSA because resistance is common.

## Q Fever



Query Fever, or Q fever, is a zoonotic bacterial disease found worldwide and is caused by the microorganism *Coxiella burnetii*. No vector is

needed for transmission from animal to animal or animal to human. Dr. E. H. Derrick first described a febrile disease seen in abattoir workers in Australia in 1935 and is likely to have named the newly observed animal-related disease as "Q fever." Later, two scientists, Dr. Herald Cox and Sir Frank Burnetti, isolated the causative organism that was named for them in recognition of their work—*Coxiella burnetii*. In 1999 the febrile illness Q fever or *C. burnetii* became a reportable disease in the United States due to its potential as a bioterrorism agent (rapid aerosolization, high rate of human infectivity, and stability in the environment). Globally, however, the disease is not universally reported, leaving scientists with no reliable numbers of cases occurring each year.

Illness in humans is commonly acquired through airborne inhalation of *C. burnetii* in dust contaminated by placental tissues from the birthing

process in home pets such as cats, farm animals (goats, sheep, and cattle), and contaminated animal products (wool, meat, and milk). Veterinarians and abattoir workers often present with symptoms of chills, fever, malaise, and severe sweats. Using x-ray examination, pneumonitis may be found without cough and mucus being prominent. An acute granulomatous hepatitis is often reported in severe cases. Heart valve damage may occur after endocarditis begins and may have an indolent course extending for years afterwards.

Laboratory diagnosis confirms Q fever by a rise in antibodies during the interim period between acute and convalescing stages, by IgM detection through Immunofluorescent (IF) testing or Elisa. Case fatality rates are generally 1 to 4% with those individuals developing endocarditis requiring extensive use of antibiotics. Physicians treating such patients have reported a post-Q fever fatigue syndrome lasting indefinitely.

Inactivated vaccines are available for abattoir workers, laboratory technicians, and veterinary researchers working with pregnant sheep. The vaccine is not commercially available to the public and is only obtainable

by physicians from Fort Derrick, Frederick, Maryland.

For humans with acute cases of Q fever, the drugs of choice for treatment are the tetracyclines (usually doxycycline) given orally for 15 to 21 days. Patients with valvulopathy may be treated with doxycycline and hydroxychloroquine. Infected heart valves may require surgical replacement for hemodynamic reasons. Pregnant women should be treated with cotrimoxazole for the duration of the pregnancy.

Methods of prevention for the general public include use of pasteurized milk and milk products; cooking meats thoroughly; avoiding farms where cows, sheep, and other animals are giving birth; and also avoiding the handling of wild animals with newly born offspring. Any human contact with gestating animals should be approached with caution and a thorough washing of hands and clothing afterward should be strictly observed.

Mecklenburg County has received one report of Q fever in 2010.

For more information, contact Al Piercy at 704.336.6440 or [AlPiercy@MecklenburgCountyNC.gov](mailto:AlPiercy@MecklenburgCountyNC.gov).



On January 13, 2010, The CDC released a measles update for persons traveling

internationally. Measles remains a common disease in many parts of the world. It is estimated that 10 million persons are infected each year with 197,000 deaths. There were four large outbreaks documented internationally in 2009. Six hundred sixty (660) confirmed measles cases were reported from April-

June 2009 in the United Kingdom primarily in England and Wales. Nine hundred forty (940) laboratory-confirmed cases and four deaths were reported in South Africa from January-October 13, 2009. Burkina Faso reported 51,000 cases and 300 deaths in 2009. Chad reported 1,256 cases and 15 deaths from January-November 22, 2009.

Regardless of the travel destination, international travelers should be up to date on immunizations. Persons 12 months or older should have received two doses of MMR or live

measles-containing vaccine. Persons are considered immune if they have had physician-diagnosed measles; have laboratory proof of immunity; or were born before 1957. Children 6-11 months who are traveling outside the United States should receive the first dose of measles-containing vaccine but this dose should not be counted as part of the routine series.

For further information, contact Jane Hoffman at 704.336.5490 or [Jane.Hoffman@MecklenburgCountyNC.gov](mailto:Jane.Hoffman@MecklenburgCountyNC.gov).

## International Measles Update

## Reporting Communicable Diseases – Mecklenburg County

To request N.C. Communicable Disease Report Cards, telephone 704.336.2817

Mark all correspondence "CONFIDENTIAL"

### Tuberculosis:

TB Clinic	704.432.2490
Mecklenburg County Health Department	FAX 704.432.2493
2845 Beatties Ford Road	
Charlotte, NC 28216	

### Sexually Transmitted Diseases, HIV, & AIDS:

HIV/STD Surveillance	704.432.1742
Mecklenburg County Health Department	FAX 704.336.6200
700 N. Tryon Street, Suite 214	
Charlotte, NC 28202	

### All Other Reportable Communicable Diseases including Viral Hepatitis A, B & C:

#### Report to any of the following nurses:

Freda Grant, RN	704.336.6436
Jane Hoffman, RN,	704.336.5490
Elizabeth Quinn, RN	704.336.5398
Belinda Worsham, RN	704.336.5498
Penny Moore, RN	704.353.1270
Communicable Disease Control	FAX 704.353.1202
Mecklenburg County Health Department	
700 N. Tryon Street, Suite 271	
Charlotte, NC 28202	

### Animal Bite Consultation / Zoonoses / Rabies Prevention:

Al Piercy, RS	704.336.6440
Communicable Disease Control	FAX 704.432.6708
Mecklenburg County Health Department	
618 N. College St.	
Charlotte, NC 28202	
or State Veterinarian, Carl Williams, DVM	919.707.5900
State after hours	919.733.3419

### Child Care Nurse Consultant:

Elizabeth Young, RN	704.336.5076
Communicable Disease Control	FAX 704.353.1202
Mecklenburg County Health Department	
700 N. Tryon Street, Suite 271	
Charlotte, NC 28202	

### Suspected Food borne Outbreaks / Restaurant, Lodging, Pool and Institutional Sanitation:

Food & Facilities Sanitation	(Mon-Fri)	704.336.5100
Mecklenburg County Health Department	(evenings; Sat/Sun)	704.432.1054
700 N. Tryon Street, Suite 208	(pager evenings; Sat/Sun)	704.580.0666
Charlotte, NC 28202	FAX	704.336.5306

**Mecklenburg County Health Department**